EMBALMER INTERN CASE REPORT

Illinois Department of Financial and Professional Regulation
320 W. Washington Street, 3rd. Floor
Springfield, Illinois 62786

SUPPORTING DOCUMENT

CR-EMB

1. Complete and sign this case report. Incomplete or illegible case reports will not be processed.
2. At the end of each completed quarter, e-mail all applicable case reports, compiled in one PDF to: ***FPR.PSSUnit@Illinois.gov***.

NAME: (*and maiden name if applicable*)	LICENSE NUMBER:
EMAIL:	PHONE NUMBER:
ADDRESS: ☐ *Check if address changed*	
LICENSED EMBALMER NAME:	EMBALMER LICENSE NUMBER:
NAME AND ADDRESS OF FUNERAL HOME:	

CASE IDENTIFICATION

INTERN CASE REPORT NUMBER: (i.e. 1 through 24)	EMBALMING OPERATION DATE:	TIME ELAPSE BETWEEN DEATH & EMBALMING:

DECEASED IDENTIFICATION

NAME OF DECEASED:	DATE OF DEATH:	AGE OF DECEASED:
CAUSE OF DEATH:		DATE OF SERVICE:

PLACE OF DEATH: *(Check one)* ☐ HOME ☐ NURSING HOME ☐ SCENE ☐ MEDICAL EXAMINER / CORONER ☐ OTHER ____________

EMBALMER INTERN CASE REPORT

CONDITION OF REMAINS: (Check all that apply)

☐ Normal	☐ Decomposing	☐ Tumor/Ulcer	☐ Rigor Mortis	☐ Donation
☐ External/Internal Wounds	☐ Skin Slip	☐ Gangrene	☐ Autopsy	☐ Emaciated
☐ Jaundice	☐ Mutilation	☐ Purge	☐ Edema	☐ Tissue Gas

DESCRIBE TEST FOR DEATH:	CAVITY FLUID NAME:
FEATURES SET: ☐ YES ☐ NO	AUTOPSY CASE: ☐ CRANIAL ☐ COMPLETE ☐ PARTIAL
METHOD USED: (i.e. needle ejector, suture, etc.)	DONATION: (i.e. eyes, skin, bone, organs, etc)
POINT OF INJECTION: (arteries, pre or co-injections, etc.)	VISCERA TREATMENT: ☐ YES ☐ NO
POINT OF DRAINAGE:	DESCRIBE SUTURING:
METHOD OF INJECTION: ☐ MACHINE ☐ OTHER *(Check one and describe)*	INSTRUMENT DISINFECTION: ☐ YES ☐ NO
FLUID COMPANY / TRADE NAME & TYPE:	HAZARDOUS MATERIAL DISPOSAL METHOD: *(Check one and describe if other)* ☐ BIOHAZARD BAG ☐ SHARPS ☐ OTHER
AMOUNT OF FLUID OUNCES USED:	
AMOUNT OF WATER USED:	UNIVERSAL PRECAUTIONS USED: (check all that apply) ☐ GLOVES ☐ GOWN ☐ MASK ☐ FACE/EYE SHIELD ☐ SHOE COVERING/PREP SHOES
CAVITY TREATMENT: ☐ YES ☐ NO	
REASPIRATED: ☐ YES ☐ NO	TOTAL AMOUNT OF TIME TO COMPLETE:
	EMBALMING REPORT COMPLETED: ☐ YES ☐ NO *(if YES, please attach)*

Describe Special Restorative Treatments (i.e. tissue builders, wax, etc.):

____

____

____

____

Describe Cosmetic Application:

____

____

____

____

Describe Dressing Procedure of Remains:

____

____

____

____

Summarize this case in detail. How was this case different?:

____

____

____

____

CERTIFICATION

We certify that this case report and the information herein are true and accurate.

Intern Signature: ______________________ Date: ______________

Embalmer Signature: ______________________ Date: ______________

FOR OFFICIAL USE ONLY

Date reviewed by Board Member: ______________ This case report is: ☐Approved ☐Denied

If denied, reason for denial: ______________________________

____

____

Board Member Signature: ______________________ Date: ______________